DD Services for Participants Frequently Asked Questions

Questions	Answers
What is the Bureau of Developmental Disability Services?	The bureau is a part of the Division of Medicaid and oversees eligibility, prior authorization, and quality outcomes for services to adults with developmental disabilities.
What is care management?	Care management is a process that the Department uses to assure that you receive the quality services that you need due to your disability. A Medicaid employee called a "care manager" reviews the individual support plan that requests services in order to make sure that the services approved meet your needs, that you receive the appropriate amount of them, and that the entire cost of the services you receive is also appropriate. The purpose of care management is to make sure you receive the right care, in the right place, at the right price, and with the right outcomes. Our goal is to improve your health and safety, and to promote your rights, self-determination, and independence.
Who are the Independent Assessment Providers (IAP) and what do they do?	The IAP has been contracted by the Department to review your documentation, do your assessment, and determine if you're eligible to receive adult developmental disability services.
How do I know if I'm eligible for adult developmental disability services?	The Idaho Centers for Disability Evaluations uses an Independent Assessment Provider (IAP) to do an evaluation and decide if you are eligible. Eligibility is determined on functional, behavioral, or medical issues and is based on the rules established by the state and federal government and the federal Center for Medicare and Medicaid Services.
What is the SIB-R?	"The Scales of Independent Behavior – Revised" (SIB-R) is an assessment that is used by Medicaid to determine your ability to function on your own. To get an accurate assessment, someone who knows you very well is asked a series of questions about you. The SIB-R is given by an IAP at the Idaho Center for Disabilities Evaluation.

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Can I get a copy of my SIB-R assessment?	The SIB-R report is sent to your plan developer who will share it with you and your person centered planning team. To get a personal copy of your SIB-R report call the Idaho Center for Disabilities Evaluation in your region.
	Region 1: (208) 772-8502
	Region 2: (208) 700-5044
	Region 3 & 4: (208) 373-1730
	Region 5: (208) 736-5711
	Region 6: (208) 282-5465
	Region 7: (208) 525-7050
What is my budget?	The budget is the total amount of money Medicaid can spend on your services. Each year, the Department determines your budget by measuring your ability to be independent, behaviors that limit your independence, your medical needs, and other things related to your disability. This information is gathered during assessment meetings using a form called "The Inventory of Individual Needs" assessment tool.
What will happen if my service needs cost more than my budget?	You are notified of your budget amount as part of the initial and annual eligibility determination process.
	 You request an appeal of your budget through the Department's Administrative Procedures Division. You must include in your appeal request documentation from a licensed professional that has completed an evaluation in the specific need area that is inaccurately assessed.
	The documentation must include recommendations for treatment that would require more funding than was assigned.
	You may contact your Service Coordinator to assist you with this process.
What is prior authorization?	Prior authorization means that the services you need are approved by Medicaid before you begin receiving them. To get your services prior authorized, your completed individual support plan will be reviewed and authorized by the Care Manager responsible for reviewing your plan. You plan is written and submitted to the Department by a plan developer whom you choose.

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What services need to be prior authorized?	 Home and Community Based Waiver services. Developmental Disability Agency services. Targeted Service Coordination/Plan Developer services for adults. Transportation to and from community activities.
What does it take for my services to be prior authorized?	 Before your services can be prior authorized they must: Meet your needs. Be identified on your plan. Be agreed upon by you through the person centered planning process. Be within the budget guidelines specific to your assessment outcome.
What happens if my service plan costs are higher than my assigned budget?	 Your assessment has provided a budget for your services that you must adhere to unless: It has been determined that you need intense or high supported living and you are receiving services in your own home or apartment. When it has been determined that you do fall into this category and your plan costs are higher than your assigned budget, you may request an exception review if your person centered planning team is unable to develop a plan to meet your needs within the assigned budget. Your plan developer can help you with this process. These requests must include documentation to validate additional support is medically necessary and is required to assure health and safety for you to live in the community.
Who will help me manage my budget and services?	 Your plan developer will discuss your plan with you and your person centered panning team in order to come to agreement on your services and a budget. You and your plan developer may use the regional care manager when there are questions about services or the budget. If the regional care manager denies services on your plan, you can ask for an appeal through the Department's Administrative Procedures Unit on the denial of specific services.

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What are the circumstances that would result in a service denial?	 Some services might not be approved if: You have duplicate services on your plan. You have services that don't meet your needs based on your assessment. You can receive the services that meet your needs at a lower price, or community provided support.